

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155218</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/15/2016</b>	
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>2300 GREAT LAKES DR</b> <b>DYER, IN 46311</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00189051 and Complaint IN00190136.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 11/20/2015. This visit included the PSR to the Investigation of Complaint IN00186499.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaint IN00187603 completed on 12/1/15.</p> <p>Complaint IN00189051-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00190136-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: January 13, 14, and 15, 2016.</p> <p>Facility number: 000123 Provider number: 155218 AIM number: 100266720</p> <p>Census bed type: SNF/NF: 98 Total: 98</p> <p>Census payor type: Medicare: 16 Medicaid: 58 Other: 24 Total: 98</p> <p>Kindred Transitional Care and Rehabilitation was found to be in compliance with 410 IAC 16.2-3.1</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 in regard to the Investigation of Complaints IN00189051 and IN00190136.  Quality review completed by 26143, on January 21, 2016.	F 000			